DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY PLETED 07/2013
	PROVIDER OR SUPPLIE		2901 B	ADDRESS, CITY, STATE, ZIP C EVERLY DR IN 46408	CODE	
				111 +0+00		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	RECTION	(X5)	
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	COMPLETION DATE
W000000	REGUETTORT	KEEC IDENTIFIED IN CHAINTION	into			Ditte
11000000						
	This visit was for a post-certification revisit survey to the extended annual		W000000			
	1	nd state licensure survey				
		completed on 5/3/13.				
	to a rail sarvey	completed on 3/3/13.				
	Dates of Survey	v: 6/5, 6/6 and 6/7/13				
	Facility Numbe	r: 001073				
	Provider Numb	er: 15G559				
	AIMS Number:	100239890				
	Surveyors:					
	Paula Chika, Ql	IDP-TC				
	Christine Colon					
		,				
	These deficienc	ies also reflect state				
		ordance with 460 IAC 9.				
	_	completed 6/17/13 by				
	Ruth Shackelfor					
	Ruth Shackello	iu, QIDI .				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001073

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G559	B. WIN			06/07/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EVERLY DR		
APC OF	NORTHWEST INDI	ANA INC. THE			IN 46408		
	NONTHWEST INDI	ANA INO, TTL		GAIXT,	111 40400		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000159	PROFESSIONAL Each client's active be integrated, coordinated at the office on 6/6/13 of the ISP dated following training staff calls her natures pond by turning staff When in a will participate in hand over hand a choice [client #1] she wants When while she is invotable [client #1] will contain the table after difficient with the table after difficient #1] will wipe her the record did not client #1's training if she made progobjectives. An interview with	retreatment program must ordinated and monitored by I retardation professional. Plient #1's record was facility's administrative at 11:25 A.M Review 9/19/12 indicated the reg objectives: "When me [client #1] will mg her head towards group activity [client #1] in the group activity with ressistance When given a large will reach for the one on her name is called olived in an activity, rease the activity When oal, [client #1] will touch number on it When done will wipe her spot at the	WO	00159	The service coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on assessing a client's ability to participate in a program obtaining wheelchair assessments, sensorimotor assessments, communication skills, implementing physical therapy recommendations, informal training opportunities, monitoring objectives, monitoring for progress/regression, by the Behavio health director by 7/7/13. To ensurthe QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.	r e	07/07/2013
		facility's administrative					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 07/2013
	PROVIDER OR SUPPLIER		2901 BI	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	office on 6/6/13 SC/QIDP indica documentation a	at 12:55 P.M The ted there was no vailable for review to nitored client #1's				
	7	led to re-assess client to ensure an appropriate 7210.				
	4. The QIDP fai sensorimotor ass Please see W218	essment for client #1.				
	`	led to assess client #1's skills. Please see W220.				
	Physical Therap	iled to address client #2's y recommendation for an n. Please see W227.				
	identified basic i	led to address client #1's needs in regard to eting. Please see W242.				
	implemented cli- objectives when	led to ensure facility staff ent #1 and #2's training formal and/or informal isted. Please see W249.				
	and #2's objective	led to monitor client #1 res to determine if the rs were achieved. Please				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G559	A. BUII B. WIN	LDING G		06/07/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	NORTHWEST INDI				EVERLY DR IN 46408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and #2's objective clients had regrest acquired. Please 11. The QIDP far and #2's objective and #2's objecti	niled to monitor client #1 es to determine if the make progress after three					
	and #2's objective clients could be	niled to monitor client #1 res to determine if the considered for training ctives. Please see W258.					
	facility failed to	was cited on 5/3/13. The implement a systemic n to prevent recurrence.					
	9-3-3(a)						
	record review fo (#1 and #2), the Coordinator (SC Disability Profes monitor clients' I objectives as no been completed QIDP failed to n	ation, interview and r 2 of 2 sampled clients facility's Service)-Qualified Intellectual esional (QIDP) failed to Individual Support Plan monthly summaries had from 9/12 to 2/13. The nonitor client #1 in regard addressing identified					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIP A. BUILDING B. WING		OO	(X3) DATE : COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		STF 29)1 BE	ODRESS, CITY, STATE, ZIP CODE VERLY DR N 46408	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and #2, and to er implemented clic	ic needs for clients #1 asure facility staff ent #1 and #2's training lined in the clients' ISPs.					
	Findings include						
	6/6/13 at 11:20 A Individual Suppo	cord was reviewed on AM. Client #2's 9/26/12 ort Plan (ISP) indicated e following objectives:					
	-To learn to identify pictures used for communication with verbal prompts by 9/30/13.						
		tivity to increase for 10 minutes with verbal 13.					
	-To point to 6 pic communication I the last 10 session	book correctly 9 out of					
	•	I with a dime and quarter, nt/gesture with 50 % y 9/30/13.					
	_	at the table. with 50% r 2 consecutive months					
		tion is administered, espond correctly by					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G559		LDING	NSTRUCTION 00		ESURVEY LETED 7/2013	
	PROVIDER OR SUPPLIER		 2901 BE	DDRESS, CITY, STATE, ZIP COD EVERLY DR N 46408	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	-To let staff know to the toilet by p 2 consecutive more and the consecutive more and the consecutive more and the consecutive more and the complete mentioned object client had met the 9/26/12 ISP was a consecutive with S (SC)/QIDP on 6 am not that far in on what I can do (computer progresshe had not revise objectives/data to	ervice Coordinator /6/13 at 1:38 PM stated "In program yet. Limited with that program am)." The SC indicated				

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G559	A. BUII	LDING	00	COMPLETED 06/07/2013	
		10000	B. WIN			00/01/	2010
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	2901 BEVERLY DR GARY, IN 46408				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000210	assessments or re	ter admission, the eam must perform accurate eassessments as needed e preliminary evaluation	Wo	00210	A wheelchair assessment for Client #1 and all others in need of assessment will be schedule by 7/7/13. The community service nurse will review the client for assessment needs monthly and will then fade to quarterly assessment and will refer to the Health care manager for any new assessments that are required. The Service coordinator will audit the file weekly until all current assessments are obtained and will then fade to monthly and quarterly assessments.		07/07/2013
	record review for (client #1), the faction the client #1's wheeled appropriate fit. Findings include: An evening observable group home of until 6:30 P.M custom wheelchathorizontal strap with the context and under/records.	r 1 of 2 sampled clients acility failed to re-assess chair to ensure an rvation was conducted at the condition of 5:00 P.M. Client #1 utilized a the for mobility. A the client's arm pits. Strap velcroed/fastened					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	IG		06/07/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			2901 BE	EVERLY DR	
	NORTHWEST IND			<u> </u>	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
		client. Client #1's				
	wheelchair had knee/leg straps/braces for					
		them in position that				
	_	er by velcro. Client #1				
		from the chest strap by				
	pulling on the ve	elcro until it became loose				
	and undone. Du	ring the entire				
	observation perio	od, client #1 was turned				
	to the side in her	wheelchair with one foot				
	up in the seat of	her wheelchair and the				
	other leg/foot lea					
	A review of clie	nt #1's record was				
		6/13 at 11:25 AM. Client				
		ividual Support Plan				
		d not indicate client #1				
		a not indicate entire #1				
		assessment to ensure				
	proper fitting.					
	An interview wi	th staff #1 and #2 was				
		5/13 at 5:30 PM. Staff #1				
		client #1's chest				
		I not fit the client				
	_	#1 indicated the client had				
		harness on her previous ff #1 stated the client's				
		would fold up and did not				
		le" for the client as it laid				
	across the client'	s breast.				
	An intomicour	th administrative staff #2				
		n 6/6/13 at 12:55 P.M				
		taff #2 indicated they				
	were not sure if	client #1's wheelchair				

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OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 06/0	TE SURVEY MPLETED 07/2013			
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
IAG	fitted her appropriately. Administrative staff #2 did not locate and/or provide documentation of a wheelchair evaluation for the client to ensure the client was appropriately evaluated. This deficiency was cited on 5/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)				DATE			

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FORM APPROVED
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE COMPL		
		15G559	A. BUII B. WIN			06/07/	2013
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	2901 BEVERLY DR GARY, IN 46408				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W000218	483.440(c)(3)(v)	ESC IDENTIF TING INFORMATION)		IAG			DATE
	INDIVIDUAL PRO The comprehensi	OGRAM PLAN ve functional assessment sorimotor development.	Wo	00218	A conserv motor assessment for		07/07/2013
			Wo	00218	A sensory motor assessment for Client #1 and all others in need of assessment will be schedule by 7/7/13. The community service nurse will review the client for assessment needs monthly and will then fade to quarterly assessment and will refer to the Health care manager for any new assessments that are required. The Service coordinator will audit the file weekl until all current assessments are obtained and will then fade to monthly and quarterly assessments	у	07/07/2013
	interview for 1 o (client #1), the fa sensorimotor ass						
	Findings include	:					
	the group home of until 6:30 P.M	rvation was conducted at on 6/5/13 from 5:00 P.M. During the entire od client #1 utilized a nobility.					
	at 11:45 A.M For not indicate a ser	d was reviewed on 6/6/13 Review of the record did assorimator assessment.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 07/2013
	PROVIDER OR SUPPLIER		2901 B	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	notes and/or cha #1's OT/PT eval- completed and/o					
	conducted on 6/6 SC/QIDP indicated wheelchair for an indicated client # sensorimotor ass This deficiency of facility failed to	th the SC/QIDP was 6/13 at 12:55 P.M The ted client #1 used a mbulation. The SC/QIDP #1 did not have a ressment completed. was cited on 5/3/13. The implement a systemic in to prevent recurrence.				

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PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED
		15G559	A. BUII B. WIN			06/07/	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			2901 B	EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
W000220	483.440(c)(3)(v)	LSC IDENTIFTING INFORMATION)		TAG			DATE
W000220	INDIVIDUAL PRO	ve functional assessment	Wo	00220	A Speech and language accessment		07/07/2013
	Decident		WO	00220	A Speech and language assessment for Client #1 and all others in need of assessment will be schedule by 7/7/13. The community service nurse will review the client for assessment needs monthly and will then fade to quarterly assessment and will refer to the Health care manager for any new assessments that are required. The Service coordinator will audit the file weekl until all current assessments are obtained and will then fade to monthly and quarterly assessments	у	07/07/2013
	record review for	ation, interview and r 1 of 2 sampled clients acility failed to assess the leation skills.					
	Findings include	:					
	between 5:00 P.M. group home, clie communication is speak. Facility sany communicate client and/or proving the street of the str	3 observation period M. and 6:30 P.M., at the ent #1 was non-verbal in n that the client did not taff did not implement ion training with the vide any assistive devices to communicate her					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		15G559	B. WIN			06/07/	2013
NAME OF P	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODELIMEST IND	IANIA INIC. THE			EVERLY DR		
	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG		d was reviewed on 6/6/13		TAG	Birtelinery		DATE
		Client #1's 9/19/12					
		ort Plan (ISP) and/or client #1 had the					
	following object	1705.					
	_ "[Client #1] 557	ll continue to learn to					
	respond to her na						
	respond to her hi	anne.					
	-"When given a	choice of 2 items [client					
	-"When given a choice of 2 items, [client #1] will reach for the one she wants."						
	Client #1's 9/19/12 ISP and/or record did						
		nt #1's communication					
	skills had been a						
	skills had occil a	33C33C4.					
	Interview with the	ne Service Coordinator					
		t 12:55 P.M. indicated					
	client #1 was no						
		The SC indicated the					
		ed training objectives					
		communication training					
		en asked if client #1 had a					
		mmunication assessment,					
		o." The SC could not					
		nication assessment for					
	client #1.						
	This deficiency	was cited on 5/3/13. The					
	-	implement a systemic					
		n to prevent recurrence.					
	9-3-4(a)						
	I		- 1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G559	B. WING		06/07/2013
			_	EET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			1 BEVERLY DR	
ARC OF	NORTHWEST INDI	ANA INC. THE		RY, IN 46408	
				,	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE
W000227	483.440(c)(4)	ESC IDENTIF TING INFORMATION)	IAG		DATE
VV000221	INDIVIDUAL PRO	OGRAM PLAN			
		ogram plan states the			
		s necessary to meet the			
	client's needs, as	identified by the			
	•	ssessment required by			
	paragraph (c)(3)		***************************************	_	05/05/2012
		ew and record review for	W00022	energy project merupy	07/07/2013
	•	lients (#2), the client's		recommendations will be	
	Individual Suppo	ort Plan (ISP) failed to		incorporated into her IPP by 7/7/13	
	include an object	tive which addressed the		Other consumers whom received	
	client's Physical	Therapy		physical therapy assessments will also have their recommendations	
	recommendation			incorporated into their IPP by	
				7/7/13. To ensure the QIDP	
	Findings include			continues to implement these	
	i mamgs merade	•		measures the Behavior Health	
	Client #21g recor	d was reviewed on 6/6/13		Director will meet with the QIDP	
				daily until these measures are	
		lient #2's 5/9/13 Physical		completed and then weekly until	
		aluation indicated client		proficiency in implementation is	
		ility status was "At least		acquired and then will fade to	
	80% but less that	n 100 percent impaired,		bi-weekly meetings.	
	limited or restric	ted" The 5/9/13 PT			
	assessment indic	ated "Patient will			
	perform home ex	kercise program with			
	•	her caregiver to			
	maintain joint fle				
		an: to initiate supervised			
	exercises to main	_			
		itani tuncuonai			
	mobility"				
		12 ISP did not indicate			
		oned recommendation			
	had been address	sed as client #2 did not			
	have an objective	e in regard to completing			
	PT exercises.	·			

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Facility ID: 001073

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING B. WING			COMPLETED 06/07/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDI		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	6/6/13 at 1:38 PM a PT evaluation of The QIDP indicates getting a new who not indicate how recommendation exercise program. This deficiency of	(objective for an						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF12

Facility ID: 001073

If continuation sheet Page 15 of 37

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 06/07/2013		
		15G559	B. WIN	G		06/07/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE	2901 BEVERLY DR GARY, IN 46408				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000242	REGULATORY OR 483.440(c)(6)(iii) INDIVIDUAL PROTHER INDIVIDUAL PROTHE	DGRAM PLAN Ogram plan must include, Who lack them, training in sential for privacy and cluding, but not limited to, sonal hygiene, dental ling, bathing, dressing, mmunication of basic is been demonstrated that opmentally incapable of increase the client #1), the il Support Plan (ISP) the client's identified gard to dressing and		TAG 00242	Client #1 Dressing and Toileting skills will be incorporated into her IPP by 7/7/13. Other consumers whom do not currently have Dressing and Toileting skills and require such training also have these areas incorporated into their IPP by 7/7/13. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.	S	07/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15G559	B. WIN	G		06/07/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt #1's record was					
		6/13 at 11:25 AM. Client					
		indicated "[Client #1] is					
	currently receivi	ng total assistance in all					
		skills" Client #1's					
	9/19/12 ISP indi	cated the client did not					
	have training in	place which addressed					
	the client's basic	needs in regard to					
	toileting and dre	ssing.					
	An interview with staff #1 was conducted						
	on 6/5/13 at 5:30 P.M Staff #1 indicated						
	client #1 require	d total staff assistance in					
	_	g, dressing, toileting and					
		Staff #1 indicated client					
		any training in place in					
	regard to toiletin						
	legard to toneum	ig and dressing.					
	An interview wi	th the Service					
) was conducted on					
	`	P.M The SC indicated					
		have any training in					
		ressed the client's basic					
	needs of dressing						
	necus of diessing	g and toneting.					
	This deficiency	was cited on 5/3/13. The					
	1	implement a systemic					
	1 -	n to prevent recurrence.					
	pian of correctio	n to prevent recurrence.					
	9-3-4(a)						
)-3-4(a)						

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Event ID: W6DF12

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION	15G559	A. BUILDING	00	06/07/2013	
		15G559	B. WING		00/07/2013	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION	
W000249	formulated a clier each client must a treatment prograr interventions and number and frequachievement of the individual program and the individual program assed on observing record review for (#1 and #2), the implement the client (ISP) object informal training. Findings include 1. During the 6/between 6:00 And group home, client communication is speak. During the period, client #2 holding a picture Staff #1 and/or # to utilize the pict in her wheelchai interaction while breakfast and state Client #2 did not at the table as client #2 did not at the table.	terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan. action, interview and in 2 of 2 sampled clients facility failed to tients' Individual Support trives when formal and/or is opportunities existed. 6/13 observation period in that the client did not in that the client did not in that the client did not in that the living room is at in the living room is book in her lap.	W000249	Once trained the Service coording will train the direct care staff on client's new IPP and programmineeds. They will also be trained active treatment and providing training at naturally occurring opportunities. Directly following this training the service coordinand other professional staff will the home daily to ensure that stare providing these services. The monitoring will continue staff has show proficiency in programminand will then fade to three time week, weekly and then Bi weekl ensure continued implementations.	g ator visit caff iis ave ng s per y to	

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Event ID: W6DF12

Facility ID: 001073

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	COI	TE SURVEY MPLETED 07/2013	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
TAG		R LSC IDENTIFYING INFORMATION) Client #2's 9/26/12 ISP			DEFICIENCY)		
		#2 had the following					
	objectives which	n facility staff did not					
	_	n formal and/or informal					
İ	opportunities for	r training existed:					
ı	-To learn to iden	ntify pictures used for					
1	communication	with verbal prompts.					
	-To engage in accognitive skill.	ctivity to increase					
	-To point to pictures in her communication book.						
	-When presented will identify/poi	d with a dime and quarter, nt/gesture.					
	-"To set her spo	t at the table."					
	(SC) on 6/6/13 a clients' objective	he Service Coordinator at 1:38 PM indicated es should be implemented lay when opportunities for d.					
	at the group hon P.M. until 6:30 observation peri wheelchair mov spastically, sat v	observation was conducted ne on 6/5/13 from 5:00 P.M. During the od client #1 sat in her ing her arms about vithout an activity and/or thout an activity except to					
l		em to hold and/or to place					

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Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G559	B. WIN			06/07/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	ŧ.		2901 BE	EVERLY DR	
	NORTHWEST INDI	IANA INC, THE			IN 46408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		of the client. Client #1				
		he item and/or dropped				
	the items she wa	s handed. During the				
	above mentioned	d observation periods,				
	client #1 was not	n-verbal in				
	communication i	in that the client did not				
	speak. No comn	nunication training was				
	provided and/or	offered to the client.				
	During the 6/6/1	3 observation period				
	between 6:00 AM and 8:15 AM, at the					
	group home, client #1 was non-verbal in					
	communication in that the client did not					
		and #2 did not provide				
	_	ion training with the				
	1 -	er the client a choice of				
		er the cheft a choice of				
	items.					
	A review of clien	nt #1's record was				
	conducted on 6/6	6/13 at 11:25 A.M				
	Client #1's 9/19/	12 Individual Support				
		ated client #1 had the				
	following object					
	15110 111111 001000					
	-Respond to her	name				
	11XX/1	.1				
	_	choice of 2 items, [client				
	#1] will reach fo	r the one she wants"				
	-"When her nam	e is called while she is				
	involved in an ac	ctivity, [client #1] will				
	cease the activity"					
		,····				
	-Wipe her spot a	t the table after dinner				

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Event ID: W6DF12

Facility ID: 001073

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	OF CORRECTION OF CORRECTION 15G559	(X2) MULTIPLE CO A. BUILDING B. WING	00	— CON 06/0	TE SURVEY MPLETED 07/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
	-"Before medication is administered, [client #1] will respond correctly (reach for medications)"						
	-Wash her face						
	During the 6/5/13 observation period facility staff did not implement client #1's above mentioned ISP training objectives when formal and/or informal training opportunities existed.						
	An interview with the Service Coordinator (SC) was conducted on 6/6/13 at 12:55 P.M The SC indicated facility staff should provide communication training with the client.						
	This deficiency was cited on 5/3/13. The facility failed to implement a systemic plan of correction to prevent recurrence.						
	9-3-4(a)						

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Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G559	B. WING		06/07/2013
			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	R.	2901	BEVERLY DR	
ARC OF	NORTHWEST INDI	IANA INC, THE		Y, IN 46408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	483.440(f)(1)(i) PROGRAM MON The individual pro reviewed at least retardation profes necessary, includ situations in which successfully compobjectives identifing program plan. Based on intervice 2 of 2 sampled composition (QI client #1 and #2's if the clients' obj Findings include 1. Client #2's rec 6/6/13 at 11:20 A Individual Support the client had the -To learn to iden communication of 9/30/13To engage in acc	INTORING & CHANGE ogram plan must be by the qualified mental assional and revised as ling, but not limited to h the client has pleted an objective or ed in the individual ew and record review for lients (#1 and #2), the ctual Disability DP) failed to monitor s objectives to determine ectives were achieved. cord was reviewed on AM. Client #2's 9/26/12 ort Plan (ISP) indicated the following objectives: attify pictures used for with verbal prompts by ctivity to increase for 10 minutes with verbal		(EACH CORRECTIVE ACTION SHOULD BE	07/07/2013 cc II
	-To point to 6 pi	ctures in her book correctly 9 out of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 06/07/2013	
		15G559	B. WING		_	07/2013
	PROVIDER OR SUPPLIER NORTHWEST IND		2901 BE	ADDRESS, CITY, STATE, ZIF EVERLY DR IN 46408	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	_	I with a dime and quarter, nt/gesture with 50 % y 9/30/13.				
	_	at the table with 50% r 2 consecutive months				
		tion is administered, espond correctly by				
	-To let staff know when she needed to go to the toilet by pointing to the picture for 2 consecutive months by 9/30/13.					
		eeth with 30% or more consecutive sessions."				
	indicated no mon had been comple mentioned object	12 ISP and/or record nthly summary/reviews eted in regard to the above tives to determine if the ne objectives since the implemented.				
	(SC)/QIDP on 6. am not that far in on what I can do (computer progr she had not revie	o determine if the client's				

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Event ID: W6DF12

Facility ID: 001073

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G559	B. WIN	G		06/07/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOIT EIEN			2901 BE	EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY,	IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. A review of c	elient #1's record was					
	conducted on 6/5	5/13 at 11:25 A.M					
	Client #1's 9/19/	12 Individual Support					
	Plan (ISP) indica	ated the client had the					
	following object	ives:					
	- "[Client #1] wi	ll continue to learn to					
		ame by October 31,					
	2012."						
	-"When given a	choice of 2 items, [client					
		r the one she wants for 5					
	-	sions by October 31,					
	2012."	sions by October 31,					
	2012.						
	"When her nom	e is called while she is					
		ctivity, [client #1] will					
	1	y of 0 of the last 0					
	sessions by Octo	ober 31, 2012."					
	WEG1:	1, 1 11 1 14					
		l touch a block with a					
		5 of the last 10 periods					
	by October 31, 2	2012."					
		ting, [client #1] will wipe					
	-	ble after dinner for 12 of					
	the last 24 session	ons by October 31, 2012."					
	-"Before medica	tion is administered,					
	[client #1] will r	espond correctly with					
	50% independen	ace for 10 of the last 10					
	sessions by Octo						
		,					

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Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559			(X2) MU A. BUII B. WING	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/07/	ETED
	PROVIDER OR SUPPLIER		F:	STREET A	ODDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	wash her face w 10 of the last 12 2012." Client #1's 9/19/ monthly summa completed of the objectives to det met the objectiv was implemente An interview wi						
	on 6/6/13 at 12:: indicated she did objectives. The any additional m reviews of the cl	55 P.M The SC/QIDP d not monitor client #1's SC/QIDP did not provide nonitoring and/or monthly lient's objectives to client had met the ISP					
	facility failed to	was cited on 5/3/13. The implement a systemic on to prevent recurrence.					
	9-3-4(a)						

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Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15G559	B. WIN			06/07/	2013
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EVERLY DR		
ARC OF	NORTHWEST INDI	ANA INC, THE			IN 46408		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000256	The individual profereviewed at least retardation profes necessary, includ situations in which losing skills alread Based on interview 2 of 2 sampled of Qualified Intelled Professional (QI client #1 and #2's if the clients lost skills. Findings included 1. Client #2's read 6/6/13 at 11:20 A Individual Support the client had the communication of 9/30/13. -To engage in accognitive skills for prompt by 9/30/13.	ew and record review for lients (#1 and #2), the ctual Disability DP) failed to monitor sobjectives to determine and/or regressed in cord was reviewed on AM. Client #2's 9/26/12 ort Plan (ISP) indicated e following objectives: tify pictures used for with verbal prompts by tivity to increase for 10 minutes with verbal 13.	W0	00256	The service coordinator will be trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on monitoring for progress/regression, by the Behavio health director by 7/7/13. Once trained the service Coordinator will review all client goals for areas in which the client may be experiencing regression or lose of skills as necessary. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to bi-weekly meetings.		07/07/2013

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Facility ID: 001073

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE : COMPL		
		15G559	A. BUI B. WIN	LDING		06/07/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		d with a dime and quarter,		1710	·		DATE
	•	nt/gesture with 50 %					
	Independence by 9/30/13.						
	_	at the table" with 50%					
	_	r 2 consecutive months					
	by 9/30/13.						
	-"Refore medica	tion is administered,					
		espond correctly by					
	9/30/13."	osponu concent of					
	-To let staff kno	w when she needed to go					
		ointing to the picture for					
	2 consecutive m	onths by 9/30/13.					
	To "brugh har to	eeth with 30% or more					
		consecutive sessions."					
	macpendence 10	consecutive sessions.					
	Client #2's 9/26/	12 ISP and/or record					
	indicated no mor	nthly summary/reviews					
	_	eted in regard to the above					
		tives to determine if the					
	_	and/or lost skills since the					
	9/26/12 ISP was	implemented.					
	Interview with S	ervice Coordinator					
		/6/13 at 1:38 PM stated "I					
	. , -	n program yet. Limited					
		with that program					
	(computer progr	am)." The SC indicated					
	she had not revie						
		o determine if the client					
	regressed and/or	lost skills.					

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Event ID: W6DF12

Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G559	B. WIN	G		06/07/2013
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			2901 BE	EVERLY DR	
ARC OF	NORTHWEST IND	IANA INC, THE		GARY, I	IN 46408	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		1				
		elient #1's record was				
		5/13 at 11:25 A.M				
	Client #1's 9/19/	12 Individual Support				
	Plan (ISP) indica	ated the client had the				
	following object	ives:				
	WEG1: #13 :	11				
		Il continue to learn to				
	•	ame by October 31,				
	2012."					
	_"When given a	choice of 2 items, [client				
	_	or the one she wants for 5				
	-					
		ssions by October 31,				
	2012."					
	-When her name	is called while she is				
		ctivity, [client #1] will				
		y of 0 of the last 0				
	sessions by Octo					
	sessions by Octo	0001 31, 2012.				
	 -"[Client #1] wil	l touch a block with a				
		5 of the last 10 periods				
	by October 31, 2	_				
	by October 31, 2	.V.14.				
	-"When done eat	ting, [client #1] will wipe				
		ble after dinner for 12 of				
	-	ons by October 31, 2012."				
		0, 0000001 01, 2012.				
	-"Before medica	tion is administered,				
	[client #1] will r	espond correctly with				
		ice for 10 of the last 10				
	sessions by Octo					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559				LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/07/	ETED
	PROVIDER OR SUPPLIER		S. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	-"When asked to wash her face w 10 of the last 12 2012." Client #1's 9/19/ monthly summa completed of the objectives to det met the objective was implemente An interview wi Coordinator (SC on 6/6/13 at 12:5 indicated she did reviews of client The SC/QIDP di additional monit reviews of the cl determine if the and/or lost acquire This deficiency facility failed to	o do so, [client #1] will ith 90% independence for sessions by October 31, 12 ISP indicated no ry reviews had been above mentioned termine if the client had ses since the 9/19/12 ISP d. th the Service CO/QIDP was conducted for the Service standard monitor monthly the straining objectives. The service and not provide any toring and/or monthly then's objectives to client had regressed		TAG	DEPICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		15G559	A. BUI. B. WIN			06/07/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			EVERLY DR		
ARC OF	NORTHWEST INDI	IANA INC. THE			IN 46408		
					114 10 100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000257	483.440(f)(1)(iii)	IITORING & CHANGE					
		ogram plan must be					
	·	by the qualified mental					
		ssional and revised as					
	-	ling, but not limited to					
	situations in which	h the client is failing to					
		dentified objectives after					
		s have been made.					
		ew and record review for	W0	00257	The service coordinator will be		07/07/2013
	2 of 2 sampled c	lients (#1 and #2), the			trained by the Staff Developme		
	Qualified Intelle	ctual Disability			Director on PPSEE, our electron		
	Professional (QI	DP) failed to monitor			Data and programming progra by 7/7/13. The service	111,	
	client #1 and #2'	s objectives to determine			coordinator will also be trained	lon	
		ed to demonstrate			monitoring for		
		asonable efforts had been			progress/regression, by the		
	made.	asonable errorts had been			Behavior health director by		
	made.				7/7/13. Once trained the servi		
					Coordinator will review all clier	-	
	Findings include	:			goals for areas in which the cli may have failed to progress	ent	
					toward identified objectives as		
	1. Client #2's red	cord was reviewed on			necessary. To ensure the QIE		
	6/6/13 at 11:20 A	AM. Client #2's 9/26/12			continues to implement these	-	
	Individual Suppo	ort Plan (ISP) indicated			measures the Behavior Health	l	
		e following objectives:			Director will meet with the QID		
	CIIOIN IIMA III				daily until these measures are		
	-To learn to iden	tify pictures used for			completed and then weekly un		
		* *			proficiency in implementation i acquired and then will fade to	S	
		with verbal prompts by			bi-weekly meetings.		
	9/30/13.				2. Hooking moonings.		
		tivity to increase					
	cognitive skills f	for 10 minutes with verbal					
	prompt by 9/30/1	13.					
	-To point to 6 pi	ctures in her					
		book correctly 9 out of					
	the last 10 session	-					
	i ine iast 10 sessio	DIIS DV 9/3U/13.	- 1		Ī		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		LDING	NSTRUCTION 00	(X3) DATE COMPI 06/07		
	PROVIDER OR SUPPLIER		2901 BE	DDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	_	I with a dime and quarter, ant/gesture with 50 % 9/30/13.				
	_	at the table" with 50% r 2 consecutive months				
		tion is administered, espond correctly by				
	to the toilet by p	w when she needed to go ointing to the picture for onths by 9/30/13.				
		eeth with 30% or more consecutive sessions."				
	indicated no mon had been comple mentioned object client failed to p	12 ISP and/or record anthly summary/reviews eted in regard to the above tives to determine if the rogress after reasonable made since the 9/26/12 ented.				
	(SC)/QIDP on 6, am not that far in on what I can do	ervice Coordinator /6/13 at 1:38 PM stated "I n program yet. Limited with that program am)." The SC indicated ewed the client's				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00		TE SURVEY MPLETED	
		15G559	A. BUILDING B. WING		06/	07/2013
	PROVIDER OR SUPPLIEF		2901 BI	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1 "	o determine if client #2 s after reasonable efforts				
	reviewed on 6/5, #1's 9/19/12 Ind	client #1's record was /13 at 11:25 A.M Client ividual Support Plan he client had the ives:				
		Il continue to learn to ame by October 31,				
	#1] will reach fo	choice of 2 items, [client or the one she wants for 5 ssions by October 31,				
	involved in an a	e is called while she is ctivity, [client #1] will by of 0 of the last 0 ober 31, 2012."				
		Il touch a block with a 5 of the last 10 periods 2012."				
	her spot at the ta	ting, [client #1] will wipe ble after dinner for 12 of ons by October 31, 2012."				
		tion is administered, espond correctly with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 07/2013	
	PROVIDER OR SUPPLIER		2901 B	ADDRESS, CITY, STATE, ZIP EVERLY DR IN 46408	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	50% independen sessions by Octo	ce for 10 of the last 10 ber 31, 2012."				
	wash her face wi	do so, [client #1] will ith 90% independence for sessions by October 31,				
	monthly summar completed of the objectives to dete	12 ISP indicated no ry reviews had been above mentioned ermine if the client had es since the 9/19/12 ISP d.				
	on 6/6/13 at 12:5 indicated she did have monthly repositives. The additional monit reviews of the cludetermine if the	th the Service)/QIDP was conducted 55 P.M The SC/QIDP I not monitor and did not views of client #1's SC did not provide any oring and/or monthly ient's objectives to client had failed to make objectives after 3 months.				
	facility failed to	was cited on 5/3/13. The implement a systemic n to prevent recurrence.				
	9-3-4(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		A. BUILDING		OO		ETED
OVIDER OR SUPPLIER		STR 290)1 BE\	VERLY DR		
					ı	(V.5)
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Œ	(X5) COMPLETION
	LSC IDENTIFYING INFORMATION)	TAC	j	DEFICIENCY)		DATE
The individual pro reviewed at least retardation profes necessary, including situations in which considered for transplant of 2 of 2 sampled of 3 sampled of 4 sampled of 4 sampled of 5 of 5 sampled of 5 of 6	by the qualified mental sional and revised as ing, but not limited to in the client is being ining towards new ew and record review for lients (#1 and #2), the ctual Disability DP) failed to monitor is objectives to determine all the considered for new objectives. : cord was reviewed on index and index in the client #2's 9/26/12 fort Plan (ISP) indicated in the following objectives: tify pictures used for with verbal prompts by tivity to increase for 10 minutes with verbal indicated in the prook correctly 9 out of	W00025		trained by the Staff Development Director on PPSEE, our electronic Data and programming program, by 7/7/13. The service coordinator will also be trained on monitoring for progress/regression, by the Behavio health director by 7/7/13. Once trained the service Coordinator will review all client goals for areas in which the client may require new objectives. To ensure the QIDP continues to implement these measures the Behavior Health Director will meet with the QIDP daily until these measures are completed and then weekly until proficiency in implementation is acquired and then will fade to		07/07/2013
	DOVIDER OR SUPPLIER DRTHWEST INDI SUMMARY ST (EACH DEFICIENCY REGULATORY OR 483.440(f)(1)(iv) PROGRAM MON The individual properties of the individual properties of the individual properties of 2 sampled of 3 sampled of 2 sampled of 3 sampled of 3 sampled of 4 sampled of 5 samp	DIDENTIFICATION NUMBER: 15G559 DIVIDER OR SUPPLIER DRTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1 and #2's objectives to determine f the clients should be considered for raining toward new objectives. Findings include: 1. Client #2's record was reviewed on 6/6/13 at 11:20 AM. Client #2's 9/26/12 individual Support Plan (ISP) indicated the client had the following objectives: To learn to identify pictures used for communication with verbal prompts by	A BUILDING B. WING STR SUPPLIER ONTIDER OR SUPPLIER ONTIDER OR SUPPLIER ORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1 and #2's objectives to determine f the clients should be considered for raining toward new objectives. Findings include: 1. Client #2's record was reviewed on 5/6/13 at 11:20 AM. Client #2's 9/26/12 individual Support Plan (ISP) indicated the client had the following objectives: To learn to identify pictures used for communication with verbal prompts by 9/30/13. To engage in activity to increase cognitive skills for 10 minutes with verbal prompt by 9/30/13. To point to 6 pictures in her communication book correctly 9 out of	IDENTIFICATION NUMBER: 15G559 INVIDER OR SUPPLIER INVIDER OR SUPPLIER INVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. 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REGULATORY OR LSC IDENTIFYING INFORMATION) 483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Intellectual Disability Professional (QIDP) failed to monitor elient #1 and #2's objectives to determine f the clients should be considered for raining toward new objectives. Findings include: 1. Client #2's record was reviewed on 5/6/13 at 11:20 AM. Client #2's 9/26/12 midividual Support Plan (ISP) indicated the client had the following objectives: To learn to identify pictures used for communication with verbal prompts by 9/30/13. To engage in activity to increase cognitive skills for 10 minutes with verbal prompt by 9/30/13. To point to 6 pictures in her communication book correctly 9 out of	DISTRICTATION NUMBER: 15G559 WING WIDER OR SUPPLIER DRTHWEST INDIANA INC, THE SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.440(f)(1)(W) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. 3ased on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Intellectual Disability Professional (QIDP) failed to monitor raining toward new objectives to determine f the clients should be considered for raining toward new objectives. Findings include: 1. Client #2's record was reviewed on 5/6/13 at 11:20 AM. Client #2's 9/26/12 andividual Support Plan (ISP) indicated the client had the following objectives: To learn to identify pictures used for communication with verbal prompts by 9/30/13. To engage in activity to increase cognitive skills for 10 minutes with verbal orompt by 9/30/13. To point to 6 pictures in her communication book correctly 9 out of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G559	B. WIN			06/07/	2013
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL IMPORTANT	IANIA INIO TUE			EVERLY DR		
	NORTHWEST IND	·		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		d with a dime and quarter,					
	will identify/point/gesture with 50 % Independence by 9/30/13.						
	_	at the table" with 50%					
	_	r 2 consecutive months					
	by 9/30/13.						
		tion is administered,					
		espond correctly by					
	9/30/13."						
		w when she needed to go					
		ointing to the picture for					
	2 consecutive m	onths by 9/30/13.					
		eeth with 30% or more					
	independence 10	consecutive sessions."					
		12 ISP and/or record					
		nthly summary/reviews					
	_	eted in regard to the above					
		tives to determine if the					
	client should be	considered for training					
	toward new obje	ectives.					
	Interview with S	ervice Coordinator					
	(SC)/QIDP on 6	/6/13 at 1:38 PM stated "I					
	am not that far in	n program yet. Limited					
	on what I can do	with that program					
	(computer progra	am)." The SC indicated					
	she had not revie						
	objectives/data t	o determine if client #2					
	1	lered for training toward a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G559	B. WIN			06/07/	2013
NAME OF B			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER	C		2901 BE	EVERLY DR		
	NORTHWEST IND				IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEFFEREN		DATE
	new objective.						
	conducted on 6/6 Client #1's 9/19/ Plan (ISP) indica following object - "[Client #1] wi respond to her na 2012."	client #1's record was 6/13 at 11:25 A.M 12 Individual Support ated the client had the ives: Il continue to learn to ame by October 31, choice of 2 items, [client or the one she wants for 5					
	_	ssions by October 31,					
	involved in an ac	e is called while she is ctivity, [client #1] will by of 0 of the last 0 ober 31, 2012."					
		1 touch a block with a 5 of the last 10 periods 2012."					
	her spot at the ta	ting, [client #1] will wipe ble after dinner for 12 of ons by October 31, 2012."					
	[client #1] will re	tion is administered, espond correctly with ace for 10 of the last 10 ober 31, 2012."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G559		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/07/2013		
	PROVIDER OR SUPPLIER		2901 B	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
	wash her face w	o do so, [client #1] will ith 90% independence for sessions by October 31,				
	monthly summa completed of the objectives to det	12 ISP indicated no ry reviews had been e above mentioned ermine if the client had es since the 9/19/12 ISP d.				
	on 6/6/13 at 12:: indicated she did have any month training objectiv provide any add monthly reviews to determine if t	th the Service (2)/QIDP was conducted (55 P.M The SC/QIDP) (1) not monitor and did not (2) reviews of client #1's (2) res. The SC did not (3) itional monitoring and/or (4) of the client's objectives (5) the client had been (6) raining toward new				
	facility failed to	was cited on 5/3/13. The implement a systemic on to prevent recurrence.				
	9-3-4(a)					

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